# TRAUMA REGISTRY QUICK REFERENCE CARD

### **Trauma Inclusion Criteria:**

Effective FY14 (January 16, 2014) and for all future entries to be entered into the State Trauma Registry.

All state designated patients must have a primary diagnosis of ICD-9 code 800-959.9. Burn patients with an ICD-9 code of 940-949 only qualify for inclusion into the trauma registry.

#### Plus any one of the following:

- Transferred between acute care facilities (in or out) **by EMS** (Ground or Air).
- Admission to the hospital <u>for any length of time to any area</u>. (This excludes patients that go to the OR from ED and are discharged home from PACU).
- Died.
- Triaged (per trauma protocols) to a trauma hospital <u>by EMS</u> (<u>Alpha/Bravo</u>). (Documentation on the EMS Patient Care Report (PCR) must reflect that the patient was brought to your facility for a needed resource. If you are the only facility in a city/county area, this criteria <u>may not</u> be used if all patients are brought to you.
- Trauma Team Activation (Alpha/Bravo).
- Any trauma patient brought to your facility by Air Ambulance.

The following primary ICD-9 diagnosis codes are **excluded** and should **NOT** be included in the trauma registry:

- ICD9 Code 905-909 (Late effects) Injury occurred  $\geq$ 30 days prior to arrival
- ICD9 Code 930-939 (Foreign bodies)
- Extremities and/or hip fractures from same height fall in patients over age of  $\underline{70}$ .

Visit http://trauma.ms.gov/trauma\_registry.html for more information.

### **Resources to Locate Patients for Inclusion**

Flag Applicable Electronic Charts
Information Services Reports
Case Managers

EMS Run Sheets
Medical Records
Admission office
TIT Generated Report
Concurrent Rounding
Emergency Department Log

**Resource Documents** (contact the State Registry Staff at 601-576-7680 if you need these documents).

- 1. Getting Started
- 2. Admin Software Navigation, Configuration and Customization
- 3. Registry User Guide
- 4. MS PreConfigured Role Based Security
- 5. DI ReportWriter User Guide, Accounts and Documentation
- 6. Using Tri-code

### **Installations/Updates**

- Notification regarding new releases will be sent electronically. The
  notice will contain a link to download the file(s) from the ftp site.
  Installation instructions and other pertinent documentation will be
  attached to the notification. Please make sure your current contact information is on file.
- 2. Please print and read the installation instructions, as well as the other accompanying documentation, prior to installing the update.
- 3. If you are unable to access the update, need a CD-copy or other documentation, or have questions about the update, please contact the DI Help Desk at 1-800-344-3668, ext 4 or email "support@dicorp.com."

### NTDB Data Submission Quick Steps:

- 1. Verify participation information with NTDB (www.ntdbdatacenter.com)
- 2. Apply the NTDB software update for your trauma registry. Save any field and menu mappings after update is applied.
- 3. Note the location where your submission file will be saved.
- 4. Review NTDB Menu Mappings to add or edit.
- 5. Confirm Facility ID mapping is correct.
- 6. Validate Records
- 7. Review Errors
- 8. Make corrections
- Create Submission
- 10. Submit File to the NTDB.

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# Transferring trauma records from Hospital to State. The VPN is no longer needed.

- 1. Log in to the CV4 Registry.
- 2. To transfer a record, the "Include in Central Site Submission" and "Record Closed" fields on the Demographic tab must be "Y."
- 3. The record must pass the CV4 edit checks to close . Also click NTDB, Validator and run the NTDB checks before closing.
- 4. On the main CV4 Registry Screen, choose File/Transfer.
- 5. Click the "Send" button to initiate the transfer.
- Collector will zip and encrypt all closed records. When this process is completed, a dialog box will appear stating that the transfer has been successful.

NOTE: If you need assistance with the transfer process, contact DI Help Desk, 1-800-344-3668, ext 4.

### **Staff Management**

Users have the ability to set up and maintain the staff of physicians, nurses, etc. that work within the facility or hospital.

- 1. From the main CV4 menu, select Setup/Staff/Manager. The Staff Record Manager screen will appear.
- 2. To add a staff member, click the "Add" button. The Add Staff screen will appear.
- 3. Enter a unique staff identification number in the Staff Id field. It is recommended that you use a number that has already been assigned by the hospital.
- 4. In the Staff Name field, enter the name of the staff member. You may enter the name in any format you choose—for example: last name, first name or first name, last name. It is recommended that you choose a format and continue to use the same format to maintain consistency.
- 5. Click the "Add" button. The Staff Editor screen will appear.
- 6. Select the Staff Type from the drop down menu.
- 7. Click "Save and Exit." To edit a staff member, highlight the name of the staff member and click the "Edit" button.

**Note:** When a staff member no longer practices or is no longer employed by your facility, select the "Disabled" checkbox.

### **Regional Email**

Using Microsoft Outlook:

- 1. Select "New".
- 2. Complete the "To" and "Subject" fields.
- 3. Click "Insert" and "File".
- 4. Locate the file. Use the down arrow to the right of the "Look In" field. The file is located in the DICORP\CV4\Server\Archive\ISend folder on the drive the CV4 is installed on. Double click the file and the system will place it in the "Attach" field. **Note:** To find out the location of CV4 right click on the CV4Reg icon, select "Properties" and look in the "Start In" field
- 5. Click "Send".
- 6. **Email your region** all files submitted to the state.

## Regional Download (Regions only)

The guidelines for Regional downloads are under construction. Until the new solution is completed, users will need to email their file.

If you have questions or need help? Contact the DI Help Desk at 1-800-344-3668, ext 4.

### **MS Report Writer Documentation**

Full documentation of reports can be found in the StandardReportDocumentation.doc document. Contact the State Registry Staff at 601-576-7680 if you need this document.

- Most of the standard reports can be categorized as a Summary Report that will display the counts and
  percentages for selected data elements or a Statistics Report that will provide statistics such as averages for the selected data elements.
- A query is a set of rules used to select a defined subset of data.
- A gather groups records into specific defined categories. When used in conjunction with a report, a
  gather will divide the report according to the specific defined categories.

## **Back-Ups** (daily or at least weekly)

- 1. Include the entire software folder (default is Collector\CV4). If space is limited, backup the CV4TRAUMA\SERVER\DB, CV4TRAUMA\SERVER\SYS, CV4TRAUMA\SERVER\USR and CV4TRAUMA\NODES folders. For DI ReportWriter (default is Collector\RW), back up the RW\SERVER\DB, RW\SERVER\SYS, RW\SERVER\USR and RW\NODES folders.
- 2. Do not overwrite your backup each night in case there is a problem with the database that is not discovered immediately or a problem with the backup media. It is recommended that monthly (4-week interval) backups be kept a minimum of one year. Contact your hospital Information System/Technology Department for your facility's standard backup policy and media type.